Middle Articles

CONTEMPORARY THEMES

Psychiatric Emergencies in an Urban Borough

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Summary: An analysis is presented of all emergency calls made in one year, "out of hours," to local authority mental health social workers as part of a comprehensive psychiatric service in an urban community. Of 212 calls received, more related to men than women, and in both sexes the peak age group was 40 to 49 years; 72% of referrals were in the psychosis or personality disorder diagnostic groups. A minority of cases referred had symptoms of only recent onset, and 70% of all calls related to patients previously known to the local services.

Introduction

Recent interest in psychiatric emergencies has been concerned more with the use of compulsory orders than with the operation of the services. Lawson's (1966) study of London before the 1959 Mental Health Act cannot represent the situation elsewhere eight years later. Roy (1966) described only some aspects of emergency work, also in London, and Clyne (1961) was not primarily interested in the psychiatric field.

The psychiatric emergency can involve general practitioners, mental welfare officers, and psychiatrists, but here we are mainly concerned with the mental health social workers' role.[1] Local authority services vary greatly. Some continue to operate with few untrained staff barely linked with the hospital psychiatrist. Others have developed a team of professional social workers closely integrated with the psychiatrist and his hospital staff. In this latter case, where a comprehensive integrated service is offered during the day but a severely limited service "out of hours," conflicts arise for the individual and the agency employing him. What happens at night, however, cannot be ignored, for it affects not only case work relationships with patients but individual and agency relationships with general practitioners and hospital psychiatric staff.

In Salford for many years the development of community mental health services has been given a high priority, and a considerable degree of unification between local authority and hospital services has been achieved (Freeman and Mountney, 1967). Two consultant psychiatrists and about a dozen mental health social workers work closely together in hospital and community institutions, and all staff tend to think of themselves as belonging to the Salford Mental Health Service. Psychiatric hospital and general hospital units, hostels, day centres, and clubs operate within this context.

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All mental health social workers liaise with a specific number of general practitioners, but several are intimately involved in "family doctor health teams," meeting regularly and working in the context of general practice. Apart from two trainees they are of at least graduate status and five are psychiatric social workers (Fryers and Mountney, 1966, 1967).

On top of the heavy routine commitments, a 24-hour emergency service requires one mental health social worker on weekly rotation to be "on call" each night and every weekend, contact being made through the night operator of the ambulance service. For a period of 12 months (from March 1966 to February 1967) these social workers provided information on each call out of hours to try to discover more precisely what constituted a psychiatric emergency, from whom the demand came, and how it was met.

Results

Patients and Referrals.—A total of 173 patients provided 212 referrals. Those referred more than once were predominantly men with a psychosis or personality disorder. The peak age group for both sexes was 40 to 49 years, but few aged 50–59 were referred. Although women represent over 60% of all mental health department referrals, men were more frequently referred at night (Tables I and II) (Eilenberg, Pritchard, and Whatmore, 1962). Twenty-five calls requested the return of an absentee patient to the psychiatric hospital As a special group these are mostly excluded from the analysis.

TABLE I.—*Out of Hours Referrals and Patients by Age and Sex (Including Hospital Absentees)*

Age	Referrals			Patients		
	M	F	Total	M	F	Total
10–19	6	2	8	5	2	7
20–29	13	21	34	9	20	29
30–39	28	14	42	22	13	35
40–49	36	26	62	24	21	45
50–59	6	13	19	5	11	16
60–69	15	14	29	13	10	23
70+	4	6	10	4	6	10
Unknown	7	1	8	7	1	8
Total	115	97	212	89	84	173

TABLE II.—*Patients and Referrals (Including Hospital Absentees)*

	No. of Times Referred					Total
	1	2	3	4	5	
Total patients ..	146	20	4	1	2	173
Total referrals ..	146	40	12	4	10	212

[1] The term "mental health social worker" includes all those employed by the Local Authority Mental Health Department in a social work capacity.

Diagnosis and Symptoms.—Psychotic patients formed the largest group, but men with personality disorder were also numerous (Table III). In 32 cases the duration of psychiatric symptoms could not be assessed, but of the others less than a quarter (38) had a recent onset, while 47 were known to have had symptoms for over a week (Table IV).

TABLE III.—*Referrals by Diagnosis, Sex, and Action Taken (Excluding Hospital Absentees)*

Presumed Diagnostic Group	Sex		Action Taken			Total
	M	F	Phone Only	Visit Only	Hospital Admission	
Psychosis	43	37	26	15	39	80
Personality disorder	39	15	33	12	9	54
Psychoneurosis ..	7	13	5	7	8	20
Organic/senile ..	8	7	5	—	10	15
Unknown	8	10	13	4	1	18
Total ..	105	82	82	38	67	187

TABLE IV.—*Admission to Hospitals by Duration of Serious Symptoms (Excluding Hospital Absentees)*

Duration of Serious Symptoms	Means of Admission to Hospital				Not Admitted	Total
	Informal	S.25	S.29	Total		
Under 24 hours ..	4	—	9	13	25	38
1–6 days	11	4	16	31	39	70
1–4 weeks ..	5	2	6	13	12	25
Over 3 weeks ..	3	1	—	4	18	22
Unknown ..	1	4	1	6	26	32
Total ..	24	11	32	67	120	187

Action Taken.—Eighty-two calls were handled by telephone only. A total of 67 calls, just over a third, resulted in hospital admission, and over a third of these entered informally. Of compulsory admissions, three-quarters were by "Section 29" because of the relative unavailability of appropriate doctors. A high proportion of the senile/organic and psychotic groups were admitted, but few personality disorders (Table III). Only a third of the patients with acute onset were admitted, but half of those with symptoms for one to four weeks' duration (Table IV).

Source of Referral.—One-third of referrals came from general practitioners and one-fifth direct from the patient or his family (Table V). The police referred many of the rest. Not surprisingly the social worker did not always agree with the referrer about the most appropriate action. Hospital admission was requested 97 times but undertaken in only 67 cases. Similarly 78 situations were handled solely by telephone, though only 45 callers had asked for this (Table V).

TABLE V.—*Referrals by Source Referred, Service Requested, and Service Provided (Excluding Hospital Absentees)*

Source of Referral	Telephone Only		Visit Only		Hospital Admission				Total
	Information or Advice		Handling of Psychosocial Crisis		Simple Removal of Patient to Hospital; Decision Already made Without M.H.S.W.		Full Procedure for Admission		
	A	B	A	B	A	B	A	B	
General practitioner	11	17	19	20	2	4	29	20	61
Patient or family	10	24	8	6	1	2	17	4	36
Hospital ..	7	16	13	8	4	4	15	11	39
Police ..	6	9	3	3	1	1	15	12	25
Others ..	11	12	2	5	4	3	9	6	26
Total ..	45	78	45	42	12	14	85	53	187

A = Service requested. B = Service provided. M.H.S.W. = Mental health social worker.

Previous History.—Only 65 referrals related to patients not previously known to the local services, and only 23 patients had no psychiatric history at all.

Nature of Emergency.—Some calls, of course, did not really demand urgent action, and a great variety of situations was revealed by visits out of hours. Many represented a sudden flair-up of symptoms with unmanageable behaviour, many with threats or fears of suicide or other dangerous behaviour. Some patients needed only supervised accommodation, not necessarily in a hospital. Only 12 patients were alone. Over half were at home with family or friends, while many others were in a general hospital ward or casualty department. Ten were in a police station. About half of those in a general hospital or police station or alone were admitted. Of those at home with relatives one-third were admitted.

Discussion

It is important to emphasize that the experience in Salford represents no general pattern of referral or care. Moreover, the mental health social worker does not handle all emergencies. The family doctor alone handles some, though from previous experience we would expect this to be a very small number in Salford. Other agencies may be brought in, particularly the Manchester Samaritans. The total of 212 calls is not an incidence of psychiatric emergencies but a departmental caseload.

Emergency situations discovered showed great variety, and therefore the appropriate action also varied enormously, but some general features may be drawn out. Most patients referred were previously known to the service, and many had long psychiatric careers, especially men with long-standing psychoses or personality disorders who tended to be referred frequently night and day. Some were repeated minor delinquents who had achieved a psychiatric label.

Otherwise the diagnosis and clinical condition of the patient were not prominent in determining the outcome of the emergency. Many patients had been exhibiting symptoms for several weeks before referral. The presence and anxiety of other people, however, were important. More than half the referrals were at home with families or friends, and few patients were without someone else to interpret their behaviour as mental illness.

So far as emergency action was concerned many patients needed only a bed for the night. The psychiatric hospital may be entirely inappropriate, but police officers and house officers on casualty duty tend to become acutely anxious when faced with deviant behaviour and demand dramatic action in psychiatric terms. The mental health social worker may disagree with their assessment, but the practical problem often dominates. In the present survey half such referrals were, in fact, admitted.

In other referrals families were closely involved. In many cases some family dispute or new external stress precipitated a crisis in a chronically tense situation. An exacerbation of the patient's symptoms may be the determining factor, but it may equally well be the product of the crisis. In either case the resulting behaviour allows the group to focus their need on him and call for help. Thus for every patient actually threatening suicide, three were referred because others feared he might harm himself or them.

We are therefore often presented not so much with a psychitric emergency according to the medical model but with a social crisis, an emergency of relationships focused on one person with a psychiatric history. The family needs help as much as the individual. The social worker by his very presence may relieve the crisis through the knowledge that the family problems will be taken up seriously and soon, and he may at the point of crisis be able to initiate a relationship which will allow the complex of family dynamics to be investigated later.

The few general practitioners who work closely with a mental health social worker are likely to be those most interested and most skilled in handling psychosocial problems. We would expect patients to go early to these doctors and early referrals

to be made in normal hours to the mental health social worker or psychiatrist. In the total survey, however, relatively few patients referred at night were acutely ill, and nearly half of all referrals were direct from patient or family or from a non-medical agency.

For most family doctors the situation is more difficult. They may be called on to handle psychosocial crises at any time, but with little experience of modern psychiatry and little understanding of the role of the professional social worker. Some are tempted to think of compulsory admission to psychiatric hospital as the most effective, easiest, or only way of solving the immediate problem, and the mental welfare officer as someone who will simply take the problem off their hands. Unfortunately the social worker, who is during the day a close colleague of the hospital psychiatrist and whose daily occupation it is to assess and handle family psychiatric problems in a fairly independent and wholly professional role, finds it difficult to act differently at night. He may be reluctant to act as policeman or taxi driver unless his professional and legal services are also required.

In his professional role, therefore, he may advise a general practitioner on the proper procedure for obtaining a bed and admitting a patient, which is the same as for any other patient unless compulsion is absolutely necessary. If there is doubt about the action required he is likely to want to visit and exercise his professional judgement on the nature of the crisis, the need for hospital admission, and the use of compulsory powers. He will want to discuss the case with the doctor and perhaps visit with him so that any decision becomes a joint one. This assertion of a professional role is likely to be more evident still with non-medical referrers. The decision is then that of the mental health social worker alone.

In the present survey the result is seen not only in the number of referrals handled solely by telephone but especially in the third of all requests for hospital admission which were not fulfilled and the third of all admissions which were informal, though out of hours. This represents a considerable lightening of the burden on the hospital staff. It is not only that the social worker makes a different assessment and decides that the hospital is not needed—at least, not needed immediately. His arrival changes the situation, and in many cases he is able to resolve the immediate crisis. His training and experience are to this end, and he has the advantage also of intimate knowledge of the local services, including the psychiatrists, and surprisingly often of the patients themselves.

It must be added that social workers like doctors vary greatly in their ability and willingness to handle difficult situations, especially at night. Our experience in Salford is that professional social workers in general desire always to give a professional service but dislike the technical tasks imposed from without, and especially resent any requests which appear to undermine their professional status. They are not alone in this. None likes to work at night, especially after a normal working day, but few would deny not only its legal necessity but its real value for patients, families, and doctors involved. The social worker must simply accept this, but its recognition by others would help.

Conclusions

In general, cases referred during the survey period represented social crises focused on a person with a psychiatric history, and were highly appropriate to the trained social worker within the psychiatric service. There is a need "out of hours" not just for a patient removal service but for professional crisis intervention, ideally by social workers with a specific psychiatric training and experience. Social work training militates against non-personal manipulative interference, but social workers are human too. Unless recognition is given to the importance of this work in community psychiatry the present terms of employment and remuneration will prevent it.

The professional social worker operates most effectively, especially at night, if he is able to use the knowledge and experience of the whole psychiatric team that serves a defined community, and maintains close working contact with family doctors. Such relationships should ease the general practitioner's burden of unavoidable psychosocial problems for which he may feel clinical medicine has little to offer. The hospital will benefit too by the effective screening of emergency admissions and by some reduction in total admissions. For the patient and his family a comprehensive psychiatric service must ensure that crises occurring unavoidably out of office hours are taken seriously and handled professionally (Caplan, 1964; Morrice, 1968).

Social workers, however highly qualified, must accept the technical tasks which give little satisfaction and cannot be divorced from "professional" work. At the same time the family doctor must be willing to accept a colleague with knowledge and skills which complement his own. This colleague may resent being ordered about, or simply left holding a particularly difficult baby, but may respond with enthusiasm to an invitation, even at night, to exercise his professional role.

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